

**Preventing Sexual Assault in Long-Term Care Facilities: Identifying Strategies for
Facilities and State Survey Agencies**

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Abstract

This research intends to demonstrate the immediate need for guidance for health care facilities and State Agencies (SAs) to prevent sexual assault and address sexuality in institutions that provide care to primarily older populations. With no clear framework to initiate investigations, SAs are often left to investigate cases of alleged sexual assault on a case-by-case basis. Health care facilities also have no clear direction or training on addressing resident sexuality, leaving a potential for sexual assault and exploitation among a vulnerable population. Care or caring about the fate of others without administrative structures, services, and programs to provide this care in a practical way is noble but ineffective (Graham, et. al., 2015). This research will serve as a way for SAs and health care facilities to work congruently to address these situations, resulting in higher resident quality of life and prevention of harm. Vulnerable populations may be especially open to violation of basic human rights. It is imperative for institutions and agencies to act accordingly to mitigate any actual or potential violations to ensure the best quality of life for everyone.

Keywords: *assault, sexuality, protection*

Introduction

The State of Maine, Department of Health and Human Services, Division of Licensing and Certification is a unique entity that provides specialty services to vulnerable and dependent people. This organization, known as a State Agency (SA), is charged by state legislative and federal statutes to regulate and enforce rules and regulations in nursing homes and residential care facilities. The people living in these facilities are considered a “dependent population”. This designates them as requiring extra consideration when addressing basic care needs and living conditions. These residents are partly, mostly, or totally dependent on a facility and its staff for life-sustaining care. As a result, care must be taken to ensure that rules and regulations are met or exceeded to provide optimum level of life functioning.

These licensed facilities are designated as long-term living arrangements. The long-term care needs of persons who are aging or living with disability or in other situations requiring assistance over an extended period are constantly evolving as their capabilities and circumstances change (Graham, et. al., 2015). People that reside at these facilities are expected to stay long-term, as opposed to a short stay at an acute care hospital or skilled rehabilitation facility. As a result, the person has elected to not remain at home, but to reside permanently in the facility. This is a significant life event, in which the facility becomes the resident’s home, and staff are working inside that home environment. Events and situations that may have occurred at home are now likely to exist in the facility environment, affecting residents, their families, and facility staff. Additionally, this new environment is inhabited with residents of different ages, rather than the typical bias of what defines an “elderly” person. For example, an age range that would have been viewed as ‘elderly’ a century ago, would today perhaps be considered as ‘middle aged’ (Ball, 2005).

One issue that has become a focal point for discussion and research is managing and addressing sexual and sexual assault situations in these facilities. Sexuality is an essential part of a person's make-up or psyche and expressing it is a basic human right. However, the sexual needs of older people are often overlooked or ignored (Bouman, et. al., 2007). With the plethora of federal and state regulations promulgated, there is little to no guidance on how facilities should address sexuality in a long-term care environment, or how SAs should investigate and enforce incidences of alleged sexual assault. One researcher stated, "Because so little effort has been put forth to address this problem at a state or national level, long-term care facilities and advocates must take the lead in creating policies that address the problem" (Doll, 2016). However, the state and federal entities that are responsible for protecting vulnerable populations and ensuring satisfactory quality of care cannot continue to abdicate this responsibility. Thus, leadership must be exercised in this arena by developing research and guidance that assists facilities with caring and protecting vulnerable residents, while honoring resident rights that allow for optimum life functioning.

Currently, these situations in licensed facilities tend to be addressed on a case-by-case basis, with no clearly defined scope of plan. The belief that older adults are asexual, especially when they require the intensive care of a nursing home, is likely the primary reason that nursing homes have not been active in considering how to manage sexual expression. Few have written policies, and when a case arises, they piece together a plan, sometimes calling upon a state ombudsman to intervene (Doll, 2016). Staff training is likely to be minimal, resulting in inconsistent responses to sexual situations or sexual assaults.

SAs may also be inconsistent in approach. Most states have regulations in statute that disallows the abuse, neglect, or exploitation of dependent persons. This clearly prohibits sexual

abuse, but what is considered “sexual abuse”? What is the definition of “consent”? If one person or both in the relationship has cognitive impairments such as dementia, TBI (Traumatic Brain Injury), or a medical condition which impairs judgement and decision making, how does that affect the investigation and outcome? These and many other questions arise as SA surveyors attempt to investigate allegations or suspicions of sexual abuse. While a clearly defined procedure and guide that encompasses all of these issues will be helpful, it will not be a total solution. However, it will provide a necessary starting point for the issue. A great deal of organizational evidence exists at the staff level (Barends & Rousseau, 2018). By engaging staff that has been involved with these investigations before, more evidence can be gathered to address the problem, such as trends and outcomes. Case studies and qualitative data will identify possible solution areas as well. This guide for SA surveyors will be considered a starting point, not a finished product.

One significant obstacle to gathering evidence is the lack of empirical data on the problem. While the problem is generally accepted, SAs do not usually keep concrete, statistical data on these incidents, especially for state-regulated facilities. Therefore, solving this problem will take more of a collaborative approach. Not all evidence from stakeholders is stakeholder evidence (Barends & Rousseau, 2018). Research was considered for its reliability and applicability. Contact with universities and gerontological research groups assisted with this process. Further, social service agencies that interact with sexual assault victims proved useful. There was a need to conduct research on incidents and facility policies with positive outcomes as well as negative outcomes. In other words, “what works” needed to be studied as well as “what didn’t work”. The discussion and implementation of policies are springboards for education and training of caregivers on issues of sexuality and aging, which will result in a more meaningful

person-centered approach to elder care (Doll, 2016). By researching in all areas with a collaborative approach and an emphasis on policy development, there is an ability to solve the initial problem to a greater degree.

While there is no concrete data that provides evidence of a problem, there is a general consensus among SAs and care facilities that exist. Evidence gathered for a solution involved these stakeholders, but also involved outside practitioners that provided guidance on these situations. By taking this collaborative approach, evidence was gathered from multiple entities that will provide a clearer direction and solution to the problem. A literature review of available research shows a paucity of information on developing guides and processes for addressing resident sexuality and alleged sexual assaults. However, there is adequate research available to identify issues surrounding the initial problem. Findings from empirical studies are often influenced by multiple variables, and thus you can never definitely prove causality (Barends & Rousseau, 2018). However, there is enough compelling evidence and research available to at least begin to address the problem, rather than solving it outright. The literature provides evidence on subjects that are critical to developing solution-oriented processes. By discovering factors that contribute to the problem, a solution became more easily identifiable. Further, other previously unknown considerations emerged that warranted inclusion in developing this guide, including legal issues and public advocacy.

Literature Review

The primary focus of this project is to develop guidance for health care facilities and state regulatory agencies to address sexual assaults or incidents. This topic has several considerations for the health care facilities. Sexual assault is defined as non-consensual sexual contact of any kind, and is considered the most hidden; least acknowledged and reported form of elder abuse (Smith, et. al., 2018). The population of the United States and many other countries is moving toward a higher median age of the population, people who reside permanently in health care facilities is increasing. Sexual attitudes and mores are changing with different generations, which are replacing older generations with different beliefs and standards. The largest consideration is that research shows state licensing agencies across the United States have been unable to develop a standard guide or procedure to investigate alleged sexual assaults. As a result, investigations and outcomes are inconsistent, thus jeopardizing the welfare of dependent resident populations that require specialized protection and advocacy. This literature review will serve as a foundation to gather information that addresses key areas for research. These will include facility environments, staff and resident attitudes toward sexuality, a review of sexuality and aging, and response and prevention of sexual assaults that may occur between residents. By researching these areas, a clear picture can develop of the problem and possible solutions. These solutions will be addressed in the final capstone project.

Sexuality and Aging

Four decades of research supports the view that older people are sexually capable, interested in sexual activity, and to varying degrees sexually active (Bauer & Geront, 1999). These interests and activities vary across the lifespan and living environments. If long-term

living arrangements are viewed as home environments, then it is reasonable to expect sexual desires and activities to continue in a facility environment. For some older people sexuality is a stable and continuous realization across the lifespan requiring little if any modification. For others sexuality may be a transformational process, requiring varying degrees of adaptation in response to changes in the internal or external environment. Such adaptation may be necessary as a result of the aging process itself, or the prevailing social milieu. What is significant is that sexual expression can play an important role in the maintenance of an older person's well-being even in a nursing home (Bauer & Geront, 1999).

These expressions of sexuality often continue when residents develop cognitive impairment, such as dementia. Research literature consists primarily of case reviews and qualitative research in these issues. Although sexuality and intimacy are part of everyday life, the manifestation of these, by those with dementia, can be complex for caregivers to address (Pinho & Pereira, 2019). The ability of an individual to consent to intimate acts is often measured by his or her performance on cognitive tests, but these narrowly defined tests may not even detect functional decision-making capacity, such as the ability to choose what to eat or what to wear. Likewise, these tests fail to consider the fluidity of cognition in dementia patients, who may perform at much higher or lower levels from one day to the next or one hour to the next (Doll, 2006). With a diagnosis of dementia comes an array of concerns such as sexual expression, ability to consent, and duty to protect from abuse and exploitation. Sexuality among nursing home patients suffering from dementia was recently studied...who reported that despite sexual behavior being mostly heterosexual and ranging from love and caring to romance and eroticism staff objected to erotic behavior (Aizenberg, et. al., 2002). As people age, the continuum of

sexual expression can pose both ethical and legal considerations for facilities, SAs, and involved stakeholders.

Facility Environments

The population residing in these facilities is considered a “dependent population”. This designates them as requiring extra consideration when addressing basic care needs and living conditions. These residents are partly, mostly, or totally dependent on a facility and its staff for life-sustaining care. Good care relationships and personalized care are likely to yield positive experiences and high quality of care in long-term care settings (Triemstra, et. al., 2021). The literature reveals fears that residents may develop surrounding dependency and personal care needs. Being dependent is one of the greatest fears of older people, and results in feelings of being a burden to others and psychological distress (Thompson, et. al., 2021). Care must be taken to ensure that rules and regulations are met or exceeded to provide optimum level of life functioning.

These licensed facilities are designated as long-term living arrangements. People that reside at these facilities are expected to stay long-term, as opposed to a short stay at an acute care hospital or skilled rehabilitation facility. As a result, the person has elected to not remain at home, but to reside permanently in the facility. This is a significant life event, in which the facility becomes the resident’s home, and staff are working inside that home environment. Literature indicated multiple psychosocial stressors that residents experience when moving into and residing at long-term facilities. Residents have agency and are often active in the process of negotiating care to ensure their physical and psychosocial well-being is maintained (Thompson, et.al., 2021). This agency may be diminished with cognitively impaired residents with dementia.

Facilities may also differ in scope and quality of service delivery. Even where the overall quality is satisfactory, differences in care quality are clearly visible between facilities (Asante, et. al., 2021). The differences revealed in research will be considered for consistent practices affecting resident care and protection from harm. Most facilities have a stated mission of quality resident care. However, the quality of care remains under pressure due to an increasing elderly population, limited resources and labor shortages that negatively affect staff capacity and responsive workforces (Triemstra et. al., 2021). These inconsistencies will be significant in assessing facility responses to alleged sexual assaults.

Facility Staff and Resident Attitudes Toward Sexuality

Health care facilities tend to be microcosmic communities that involve the personalities and attitudes of both residents and staff. These attitudes toward resident sexuality often affect the way sexual activity or response to sexual assaults are addressed, especially residents with a diagnosis of dementia or other cognitive impairment. Some research literature examines negative representations of dementia and sexuality across recent North American, European and Australian news media sources. These representations demonstrate how they support the constitution of the sexualities of persons with dementia as dangerous, and thus as requiring surveillance and restriction (Grigorovich, 2020). The media stigmatizes persons with dementia by constructing them as either sexual predators or asexual victims. The first construct explicitly incites disgust and fear towards the sexualities of men with dementia, while the second elicits a superficial form of caring towards women with dementia. Such representations preclude the recognition and support of the sexual rights of persons with dementia, including their right to experience sexual pleasure (Grigorovich, 2020).

Other research indicates findings of more moderate and positive attitudes of sexual expression in health care facilities. Care staff in all residential and nursing homes in the Borough of Broxtowe, Nottingham, Great Britain were surveyed. 234 valid research questionnaires were returned giving a response rate of 54%; the mean total ASKAS score was 60, which reflects moderately positive and permissive attitudes towards later life sexuality (Bouman, et. al., 2007). Another research study evaluated sexual attitudes in a group of independent residents in a large urban nursing home in the United States. Ten items covering different aspects of sexual attitude were scored by two board certified psychiatrists following a semi-structured interview. The study was undertaken at a large 1,200-bed nursing home providing services to both healthy independent elderly as well as geriatric patients. Participants were cognitively intact and living independently at the nursing home. Sex is graded as “moderately important” among nursing home residents, more so in males (Aizenberg, et. al., 2002). The majority of residents expressed positive attitudes towards open discussion of sexual matters and willingness to accept therapeutic interventions when needed.

Attitudes toward sexuality will begin to alter as cognitive impairments develop or are already present. Research indicates the need for flexibility when addressing sexuality in a facility environment when these impairments impact resident decision making ability. Policies emphasizing the individual lead to good care planning and a recognition that a one-size-fits-all approach does not work for people with dementia (Doll, 2006). These considerations are important to give residents the ability to continue to lead fulfilling lives, while protecting them from potential sexual abuse or exploitation. However, facilities need not be alone in this process. A team approach is essential that involved residents, physicians, families, and other stakeholders involved in the care and protection of facility residents. A lack of understanding from health care

professionals may compel older people to conform to society's expectations, more so for older women. Thus, the promotion of healthy sexuality among the elderly is a challenge for health professionals (Aizenberg, et. al., 2002). By involving these professionals in the care planning process and policy discussion, greater outcomes may be realized.

Research Implications

Long-term care residents often lack physical and cognitive abilities, making them particularly vulnerable to assault (Smith, et. al., 2018). The absence of research and discussions in prevention and investigating sexual assaults in health care facilities has led to inconsistent responses from facilities and state agencies. Avoidance of conversations with older people about their sexuality and sexual health concerns by health-care professional is commonly reported in health-care settings. This may be explained by health-care professionals' lack of knowledge and attitudes on this topic. Contrary to societal beliefs, sexual and intimate behaviors are exhibited by older adults in nursing home settings, and by those that have dementia-related diseases (Pinho & Pereira, 2019). Physicians and medical providers may not address the issue due to existing bias. Literature shows health-care professionals have limited knowledge about sexuality in older people and an inability to discuss associated issues (Chen, et. al., 2020). Facilities often avoid the subject, and fail to take pre-emptive action until a negative situation occurs between residents. This may result in punitive action from state agencies and potential litigation from resident families.

Research shows varying and inconsistent approaches to responding to sexual activity or assaults in facilities. States vary in how they determine the capacity of an individual to consent to sexual activity (Doll, 2016). Any policy discussion should involve agencies that respond to

allegations of sexual assault, such as law enforcement, advocacy agencies, and state agencies. A victim's experiences with those who respond to a criminal event can have a lasting effect on the victim (Payne, 2011). Residents should be a primary focus when developing a response to sexual assault. The literature further indicates the need for a multi-faceted approach to solving the problem. Developing clear guidance involving multiple stakeholders would improve consistency and response to ensure the appropriate application of resident rights, while providing advocacy and involvement with any sexual assault.

Research and literature on this subject show cause for action. There is a need both in Maine and across the United States for guidance and clarity on addressing sexual assaults and resident sexuality in health care facilities. The research and recommendations will serve as a critical path to enabling SAs and health care facilities to work in a collaborative manner on this issue. Vulnerable populations such as older or infirmed people are required, by statute and ethical requirements, to be deserving of protection from harm.

Analysis and Recommendations

The literature review presents a strong case for long-term care facilities and SAs to address the issue of sexual assault between residents. Sexual assaults of older people remain difficult to characterize owing to the paucity of studies, the diversity of methods, and the lack of detailed information regarding number and nature of incidences (Smith, et. al., 2018). Based on this review and comprehensive research, the following recommendations are made for identifying areas for improvement which will fulfill requirements for facilities and SAs to protect these extremely vulnerable populations. These recommendations should be viewed as important beginning steps, that will require additional future research and analysis of the problem. SAs

should establish guidelines for investigating such occurrences, and facilities should constantly evaluate programs and strategies to identify any areas for improvement.

Staff Training in Long-Term Care Facilities

There is a demonstrated need for employee training programs at facilities that address resident sexuality. These training programs should be a strong component of any resident service plan development and implementation. Helping residents achieve the highest possible level of physical, mental, and psychosocial function and well-being are crucial elements of person-centered care (Eliopoulos, 2015). Person-centered care is respectful of and responsive to each person's needs, preferences, and values, and ensures that care recipients' own values guide all decisions affecting their lives. This has involved both a rethinking of the underlying philosophy of care and a broader definition of what we mean by long-term care (Graham, et. al., 2015). Since sexuality is a significant component of people's lives, facilities should develop training programs around this issue.

Nursing students and other health care professionals receive most of their training in acute care settings. It is understandable, therefore, that they may lack an understanding of the unique aspects of long-term care. The situation is quite different in long-term care settings. Owing to the extended time that most individuals reside in a nursing home or assisted living community, be it on a temporary or permanent basis, this setting will become a home for them. For this reason, quality of life joins quality of care as an important focus of services; a holistic approach supports this focus (Eliopoulos, 2015). The facility will need to take these factors into account when developing resident sexuality training programs for staff. The training module should include such areas as ageing and sexuality, memory care, issues of consent, case studies

of historical incidents, and current facility policy and procedure. Multiple studies have focused on the institutional culture of nursing homes and how the daily routines in the traditional institutional nursing homes are designed to serve the needs of the care staff rather than those of the residents (Roberts & Pulay, 2018). A staff training program on sexuality should be just the opposite of this, focusing on person-centered care. Each resident will need to be considered as an individual person, not just another task on a duty roster.

By the facility developing, offering, and documenting training in sexuality and sexual assault prevention, potential harm to residents can be mitigated. It will also provide a solid foundation for an SA's inquiries during a routine survey or incident investigation.

Developing Facility Policies and Procedures

Sexuality is seldom considered in nursing home environments, with few policies or trainings in place to address sexual situations when they arise (Syme, et.al., 2017). A well-researched and complete policy and procedure in addressing sexual situations in long-term care facilities should be at the core of any intended training program for staff. The policy and procedure developed by a long-term facility should consider facility environment, expression of sexuality by residents, the definition and implication of consent, and when to identify and report instances of actual or suspected sexual abuse. An intentional and well-conceived sexuality policy ensures that the proper steps will be taken to meet residents' needs (Doll, 2012). This policy will not only allow residents to express their sexuality, but also protect them from potential harm. Developing a policy and procedure should be developed ahead of time to avoid the usual last-minute reaction by administration and staff after an incident has occurred. A 2015 study of 366

Directors of Nursing (DONs) found the majority of facilities (63.4%) do not have policies addressing any aspect of resident sexuality (Syme, et. al., 2017).

Long-term care facility staff and administration know their facilities and residents best. This policy should be developed with the facility environment and layout in mind when addressing resident sexuality. Nursing home designs typically do no provide clear boundaries between public and private spaces and, therefore, significantly reduce the levels of privacy that can be achieved (Doll, 2012). Some resident privacy is attained through privacy curtains, partitions, or private rooms. Facility policies should address how staff may respect residents' privacy when expressing their sexuality. In addition to this, facilities may also recognize areas where there is a potential for sexual assault, and can include this in a policy or procedure. A resident who is expressing inappropriate actions toward another resident or multiple residents may lure a resident, possibly with cognitive impairment, to an isolated or private area. The policy and procedure should allow staff to recognize this and intervene appropriately. Many influential long-term care organizations have promoted the practice of consistent assignment, that is, the same caregivers consistently caring for the same residents almost every time they are on duty (Castle, 2013). Incorporating this into a policy and procedure will allow staff to become familiar with certain residents, and thus be in the position to allow them to express their sexuality without being harmed by inappropriate actions by another resident. Further, if a sexual assault has occurred, residents may feel more comfortable relating this to a trusted caregiver.

The policy and procedure should also include explicit instructions on what staff should do if there is an actual or suspected resident sexual abuse. Acts of sexual abuse should never be ignored or tolerated and should be carefully investigated. Staff and administrators must protect and support the safety and well-being of the abuse victim (Doll, 2012). Each state has statutory

requirements for reporting and addressing sexual abuse for dependent persons. The facility policy and procedure should reflect current statutes, and follow them accordingly. The policy should also provide a detailed framework for administrators to investigate alleged sexual assaults and provide outcomes to protect and support residents, while not infringing on other residents' rights to express their sexuality by instituting draconian across the board measures. Further, in the absence of well-developed policy, administrators in nursing homes may pose certain limits based on factors such as the perceived appropriateness of the acts (e.g., only permitting sex within marital relationships), and/or the presence or lack of a dementia diagnosis. Also, facilities may operate by restricting sexual and intimate expression among residents who have been globally deemed to lack consent (e.g., threshold score on cognitive screener), instead of employing a more valid, nuanced assessment of sexual consent (Syme, 2017). It is recognized that the long-term care facility administrator has an extremely difficult job, however, developing a strong policy and procedure for resident sexuality and addressing sexual assaults will provide important support when events do occur.

Assessments and Service Plan Development

Perhaps most critical to protecting vulnerable long-term care residents and honoring resident rights is conducting appropriate assessments and developing comprehensive service plans that address areas that may include sexual expression or potential for victimization. Assessments should be conducted before a resident is even admitted to a facility, and then service planning should be a continuous process throughout the resident's stay. Staff should be knowledgeable about service plans

Assessments

Most long-term facilities that are wholly or partly federally funded utilize the most recent version of the RAI-MDS assessment tool. This assessment form does not provide any area to assess for sexuality expression, however, more relies on assessing quality indicators (QIs). QI is a computed measure based on a clinical outcome that is believed to be reflective of the quality of care. In other words, QIs are used as proxy or surrogate measures for quality of care. Outcomes can be undesirable, such as falls or pressure ulcers, or they may be desirable such as physical independence or improved continence (Estabrooks, et. al., 2013). While these QIs are critical areas to address to ensure person-centered care, it does not comprise the entire, whole person. The facility may develop its own assessment tool alongside the RAI-MDS to provide a less clinical, more holistic approach to resident care and protection which includes sexual expression or previous trauma associated with sexual assault.

On the issue of cognitive impairment or consent, facilities may use generally accepted tests or evaluations to assess for capacity to make informed decisions and avoid abuse or exploitation. Long-term care homes typically rely on testing to determine cognitive ability, generally using the Mini-Mental State Examination (MMSE) (Doll, 2012). This tool provides a baseline cognitive screen for assessors, despite the fact that cognitive impairment due to dementia or other conditions may vary at different times throughout the day. Other commonly accepted cognitive screening tools may be utilized as well. Regarding residential setting, almost half of people residing in nursing homes (that is, nursing care settings) within the United States have dementia diagnoses. Lithgow, Jackson, and Browne proposed underdiagnosis of dementia within long-term care facilities, suggesting a potential prevalence of up to 80 percent (Boyd, et. al., 2018). Therefore, the importance of cognitive screening becomes more critical when

assessing for sexual expression. Long-term care residents may consent for sexual activity in situations where they have the ability to consent, and staff may intervene or seek additional assistance in situations where a more significantly cognitively impaired resident may be sexually exploited by another resident. Facilities should always conduct pre-admission assessments on potential residents utilizing a holistic model. This will ensure that the resident fits into the current facility milieu, and avoids problems down the road with involuntary discharges or inability to maintain resident quality of care.

Service Planning

Long-term care facilities are almost always required by state and federal regulations to develop and carry out written service plans for each resident at the facility. The first step in the process is the comprehensive assessment. The next step should be utilizing a team approach to developing the service plan. This may be an obstacle in itself. Although some disciplines may discourage interprofessional collaboration, others encourage it. For example, social workers are taught the value of collaboration, but physicians are trained to take charge by assuming unquestioned leadership in an interdisciplinary endeavor. Physicians, therefore, tend to view interdependence as an inappropriate professional attribute (Nandan, 1997). A facility developing a resident service plan needs to have all stakeholders involved, including physicians, facility staff, families, and most important, the resident. The service plan should address any sexual expression that may require staff intervention or attention. This may include a resident that wishes to voluntarily participate in sexual expression, or monitoring a resident for inappropriate or assaultive behaviors.

All direct care staff should be knowledgeable about information contained in a service plan, so that resident rights are respected, and more vulnerable residents are protected from harm. Due to limited insights and understanding of older adult sexuality, nursing home staff often view sexual activity as behavior problems rather than expressions of love and intimacy (Doll, 2012). Careful service planning may assist in differentiating these behaviors and identifying appropriate interventions. This will assist staff with already difficult jobs, and allow residents dignity and respect when choosing to sexually express themselves.

Conclusions

The literature review and qualitative research conducted on this subject offers several strategies for facility staff and management. It further identifies investigative questions and objectives for SA surveyors who conduct routine inspections or complaint investigations (Appendix A). By synthesizing this research and data, clear solutions emerge to a problematic situation. While these recommendations are not exhaustive, they are comprehensive enough to warrant consideration and implementation. Further research will continue to augment these strategies as well.

As different generations and resident milieus emerge in long-term care facilities, it will remain critical to continuously evaluate facility approaches to both allow resident sexual expression and prevent sexual assault in these institutions. Continuous research and collaboration with facilities, advocates, stakeholders, and SAs will prove effective in addressing this major problem, and allow for greater quality of care in these facilities. Both facilities and SAs are charged with protecting some of society's most vulnerable populations, and addressing the issue of resident sexuality and preventing sexual assault will prove advantageous in that effort.

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Appendix A- Guidelines for State Agency Staff

This guidance is not comprehensive, nor reflects current regulatory requirements at all licensed facilities. It does, however, provide guidance on investigating issues at facilities where a case has developed that requires State Agency intervention.

Staff Training at Long-Term Care Facilities

1. Does the facility provide an in-service training program that addresses resident sexuality? If so, what areas does it address? Areas that should be considered are: resident rights, sexuality in aging, privacy, cognitive impairments, ability to consent, and signs of potential sexual abuse or assault. If there is a suspected or actual sexual assault, does staff indicate knowledge of the mandatory reporting process and facility procedure and policy?

Long-Term Care Facility Policy and Procedures

2. Does the facility have a written policy and procedure that honors resident rights to sexual expression, and provides guidance to staff and management for preventing resident to resident sexual assaults? Does this policy and procedure include areas such as mandatory reporting, protection from harm, and issues surrounding consent? Does the policy and procedure require all staff to participate in an in-service training program? When investigating an alleged sexual assault, SA surveyors should determine if the policy and procedure was followed or not. If not, what failures were evidenced? Were the failures singular or systematic?

Service Planning and Assessments

3. Does the resident assessment or initial history questionnaire include anything about sexual history or sexual expression? Are inappropriate sexual behaviors identified in the assessment? If the resident does exercise the right to appropriate sexual expression, or demonstrate inappropriate behaviors, is this addressed in the service plan? Was the service plan updated to reflect current or potentially required staff interventions?